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TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

SUBJECT: **ASSESSMENT OF THE READINESS OF KING/DREW MEDICAL CENTER (KDMC) FOR UPCOMING SURVEYS**

This memorandum is in response to your Board's request for additional information about KDMC's progress toward meeting 1) the Conditions of Participation as required by the Centers for Medicare and Medicaid Services (CMS) and 2) the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This document also describes the Department's plans for sustained service delivery should the facility not meet all Conditions of Participation in the upcoming CMS survey.

In order for a health care organization to participate in and receive payment from Medicare or Medicaid programs, it must be certified as complying with the Conditions of Participation, or standards, set forth in federal regulations. This certification is based on a survey conducted by a state agency on behalf of CMS. However, if a national accrediting organization such as JCAHO has and enforces standards that meet the federal Conditions of Participation, CMS may grant the accrediting organization "deeming" authority and deem each accredited health care organization as meeting Medicare and Medicaid certification requirements. The health care organization would have deemed status and would not be subject to CMS' routine survey and certification process, but would be subject to complaint validation surveys. JCAHO accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement. Organizations seeking Medicare approval may choose to be surveyed either by an accrediting body, such as JCAHO, or by State surveyors on behalf of CMS.

Currently, KDMC has been removed from the "deemed status" exception and must undergo a full CMS validation survey in order to continue its participation in the Medicare and Medicaid programs. The CMS and JCAHO surveys have similar but not identical standards and also differ with respect to methodology and outcome. One important difference is that JCAHO requires

evidence that their standards have been met for the previous four months, whereas CMS can accept recently implemented processes if they can be shown to be effective.

The most important immediate issue is the CMS survey. CMS has stated that they would perform a complete Conditions of Participation Survey after the facility has had one full year to operate under the Memorandum of Understanding with CMS. The Department expects CMS to conduct the survey in the next 60 to 90 days. The date and time of the survey will be chosen by CMS. The CMS survey specifically looks at actual care delivery on the days of the survey; it is fundamentally a concurrent review of care and the processes that support care.

KDMC must re-apply for JCAHO accreditation. The JCAHO survey will focus on the actual delivery of care through a "tracer" methodology but this survey also places a very heavy emphasis on evidence that processes have been in place and stable (in KDMC's case, for a minimum of four months). Currently the Department and Navigant believe that the hospital does not have the documentation in place for a December survey and are planning to schedule this survey for March 2006.

Background

The last twenty years of KDMC's history has been marked by recurrent efforts to address materially similar issues of poor management and inadequate quality. For example, problems similar to those at present were found in 1989:

> *"State health officials, who did a hospitalwide investigation of King in June [1989], released two reports earlier this month. They cited massive, wide-ranging health care deficiencies in six key areas: quality assurance, infection control, nursing, dietary services, administrative leadership and physical environment.*
>
> *"The problems are so numerous and severe, according to federal officials, that they have taken the rare step of threatening to cut off health care funds in December."*
>
> *Los Angeles Times, September 27, 1989.*

Further, in 1996, your Board undertook an effort to fundamentally reform the hospital:

> *"Instructed the Director of Health Services to immediately establish a Crisis Management Task Force, ..., to restore public confidence at the Martin Luther King, Jr. / Charles R. Drew Medical Center; ... charged with the responsibility of advising and recommending actions to the Director of Health Services ...":*
>
> *Statement of Proceedings*
> *Los Angeles County Board of Supervisors*
> *01-02-96.4.1 59 4*

The current effort to fundamentally reform KDMC began over two years ago and is different than those that preceded it in several unique ways:

- The Satcher Task Force made recommendations to change the Board of Trustees and leadership at Charles R. Drew University of Medicine and Science (Drew).
- The Board of Trustees at Drew has made fundamental and substantive changes.
- Your Board has collectively engaged the reform efforts.
- Rather than changing only the leadership of KDMC, extensive personnel actions have been taken across the organization resulting in 707 cases and 458 actions between January 26, 2004 and October 6, 2005.
- Extensive measurements of care and process have been implemented to guide the effort and to assure progress.
- An external management firm (Navigant) has been engaged under agreement with CMS providing up to 35 experienced healthcare managers from outside of KDMC to lead the reform.
- A Hospital Advisory Board (HAB) for KDMC has been formed, and includes members who are independent hospital management experts.

Milestones relating to the current reform, including their relative successes and shortcomings are summarized below:

Timeline of KDMC Milestones

Date	Event	Description
2001	JCAHO On-site Survey	KDMC receives a passing score of 82.
12/6/02	Radiology Program Withdrawal; Internal Medical Program on probation	Drew University notified by the Accreditation Council for Graduate Medical Education (ACGME) notifying them on their intent to withdraw accreditation of the diagnostic radiology residency program and that the internal medicine program, up for renewal in 11/03 was also on probation.
1/7/03	KDMC Residency Programs	DHS notifies your Board that Drew University and KDMC have been asked to provide a clear plan of correction for each citation that includes a timeline for implementation and target completion dates, for their areas of responsibility.
05/03	Surgery Program Withdrawal	Drew University receives a letter from the ACGME indicating proposed summary withdrawal of the surgery resident training program.
09/03	Satcher Task Force	Former Surgeon General David Satcher leads a task force to review faculty, leadership and hospital operations at KDMC.
10/14/03	KDMC Training Program Accreditation	ACGME's Residency Review Committee for Surgery voted to confirm the summary withdrawal of KDMC's General Surgery Training Program.

10/23/03	KDMC Management	Management Oversight Group established; includes Dave Runke, William Loos, MD, Gary Wells, and Sachi Hamai. Goal is to shore up management procedures, policies and compliance to improve the efficiency and effectiveness of KDMC's operations and services.
12/8/03	**CMS Validation Survey**	Inspectors began a four-day complaint validation survey. Preliminary findings include: **Quality Assurance Program**: Facility does not follow through on problems identified. **Nursing:** Lack of adequate assessments. **Medical Staff:** Physician Staff Association (PSA) by-laws not being followed for Governing Body reporting, lack of follow-up and documentation related to identified problems. **Governing Body:** Failure to follow reporting structures in approved bylaws.
12/15/03	KDMC Update	Management Oversight Group (MOG) established priority of improving clinical management and preparing for JCAHO survey. Search for Chief Medical Officer (CMO) concluding. Search for Chief Executive Officer (CEO) begun. MOG identified a "pattern of behavior among clinical managers that significantly challenges the attempts of new leadership to institute change". Significant actions must be taken to establish accountability, leadership and performance expectations. David Runke and William Loos, MD assigned full time to KDMC and given direct management authority to make personnel or operational changes. A JCAHO readiness assessment was completed, with findings and corrective actions initiated. GME programs reviewed, potential collaborations with other medical schools considered. An audit was begun to review the affiliation agreement and the University's performance. The Health Services Administration's Finance Chief was assigned to oversee KDMC's fiscal units.
12/19/03	KDMC Update	Patient safety issues prompt acceleration of the pace of reforms. Fred Leaf assembles a team to assist the Management Oversight Group full time. Engaged a Nursing turn-around team (the Camden Group) to conduct a thorough assessment of the current nursing staff at KDMC.
1/8/04	**CMS Survey**	CMS visits to investigate a complaint, deficiencies identified in the following conditions: **Medical Staff, Nursing Services, Emergency Services, Quality Assessment and Performance Improvement,** and **Governing Body.**

1/9/04	KDMC Update	DHS responds to Board request to provide recommendations regarding the management of KDMC and restructuring the graduate medical education programs. DHS response includes recognition of significant systems failures that are "historic and deep" and include such things as the lack of human resources processes, the absence of effective communication among managers and to staff, and a failure to implement quality assurance activities. These factors have contributed to a culture that fails to hold employees accountable for their actions and as such ultimately fails the patients and community it serves. **Plan:** Continue changes initiated in management structure. Requested authority from your board to take the necessary administrative steps to facilitate the restructuring of services at KDMC and the consolidation of services system-wide. DHS requested delegated authority to amend the nursing registry agreements to facilitate hiring of temporary staff to fill critical vacancies. DHS notified Drew University of its intent to terminate the existing agreement and replace it with a contract that reflects necessary changes in the relationship and expectations of the University. Requested authority to hire a Senior Medical Director for Clinical Affairs and Affiliations to develop and direct DHS policy related to the management of clinical activities. DHS requested the ability to vary physician pay based on the quantity and quality of work produced. Identified misalignment of incentives as the root of many of the problems at KDMC. DHS requested authorization to take the necessary steps to facilitate the consolidation or restructuring of clinical services at KDMC.
2/20/04	CMS Plan of Correction	CMS plan of correction submitted to address deficiencies identified in 1/8/04 visit.
3/3/04	**CMS Survey**	CMS visits on a complaint investigation. KDMC was deemed to be in immediate jeopardy related to deficiencies identified in **Pharmaceutical Services.**
3/15/04	CMS Plan of Correction	Plan of correction submitted to address deficiencies identified in 3/3/04 visit.
4/8/04	Intent to Engage Executive Management Consultant	Requested authority to engage a consultant (Interim CEO) to review and make recommendations regarding the facility operating structure, support functions, reallocation of resources, institution of hospital-wide performance standards, a system of accountability for performance, management of GME activities, budgeting processes and systems, staff training and current utilization of existing information technologies.
5/4-7/04	JCAHO On-site Survey	Triennial JCAHO survey conducted.

5/10/04	**JCAHO Survey Results**	JCAHO survey found problems in the following areas: **Provision of care:** incomplete history and physical exams, insufficient documentation to validate performance of ancillary assessments, timely documentation of procedures, interdisciplinary care documentation. **Communication:** insufficient documentation to confirm coordination of patient education. **Credentialing:** peer review policy lacked design elements related to selection of peer review panels, time frames for conducting peer reviews and participation by the individual being reviewed in the process. **Infection Control:** problems with the storage of equipment, procedures for cleaning surgical instruments, functioning of ventilation in negative air pressure isolation rooms. **Information Management:** documentation of information regarding current medications, allergies, and operative and invasive procedures. **Medication Management:** Inability to delineate a consistent process for identifying the first dose of medication. **Patient Safety:** Problems with equipment, documentation of chemical and biological testing of water used in dialysis, preventive maintenance for ventilators. **Physical Environment:** Number of areas requiring attention to the level of fire resistance and proper ventilation. **Quality Improvement:** Problems with the hospital's implementation of policies related to the use of human resources indicators to evaluate the potential impact of staffing on patient care; staffing shortages in March and April identified.
5/21/04	**CMS Survey**	CMS surveys Life Safety Code, finds KDMC out of compliance with various Life Safety Code standards related to plant management and building services.
6/3/04	**CMS Full Validation Survey**	CMS performs **full validation survey**, finds deficiencies in the following areas: **Nursing Services, Pharmaceutical Services, Medical Records, Food and Dietetic services, Physical Environment, and Patient Rights**
6/15/04	Engagement of Executive Management Consultant	DHS withdraws its request to engage an executive management consultant after negotiations with Superior Consulting stall over specific deliverables to be included in the contract.
8/13-14/04	JCAHO Special Survey	JCAHO makes unannounced survey visit based on responses to corrective actions submitted for May 2004 survey. Announces Preliminary Denial of Accreditation; KDMC appeals.

9/13/04	KDMC Restructuring	Progress has been made, but KDMC is far from "fixed". New management instituted new policies and protocols related to patient care, assessment, strengthening the skills competency of the nursing staff, improved management practices and restructuring of plant management. **CMS proposes entering into Memorandum of Understanding (MOU) to provide KDMC** with an opportunity to establish a sustained effort over the next 12 months, with the infusion of experts with a broad range of experience in clinical resource allocation, physician organization and competency assessment, clinical productivity measurement and organizational structure and effectiveness. The consultant would assume operational management of the medical center under the supervision and direction of DHS; monitor all major hospital systems and make recommendations for changes; evaluate governance, leadership and competency of staff; evaluate labor management issues and propose recommendations; and assess operating procedures and allocation of resources and recommend reforms. **Short Term Goal:** Within one year, restructure the clinical configuration of services at KDMC to allow for the safe management of patients and to set the stage for the long-term goal of establishing a center of excellence for multicultural public health and medicine. DHS recommends KDMC relinquish its trauma designation and take further steps to limit its volume of emergency visits. Within 90 days, phase out the trauma program.
9/15/04	**CMS MOU**	Requested Board authority to enter into MOU with CMS for one year from date of execution to 9/30/05 and authorize Beilenson hearing for closure of Trauma services.
9/21/04	CMS Plan of Correction Submitted	CMS plan of correction submitted for surveys conducted on 5/21/04 and 6/3/04.
10/21/04	Drew University	Assessment of future viability of Drew University as an affiliated medical school. University officials indicated their commitment to initiate faculty recruitment, provide competitive salaries, link academic stipends to academic accomplishments, establish Board certification as a requirement for all new faculty and others.
10/22/04	**CMS survey**	CMS performs validation follow up survey, identifies deficiencies in the following conditions: **Governing body, patient rights, quality assessment and improvement, medical staff, nursing services, pharmaceutical services, radiological services, food and dietetic services, physical environment, infection control, emergency services and respiratory care services.**
11/12/04	Reduction of Trauma	Requested approval of proposed reduction of trauma services to focus clinical care

11/16/04	Review of KDMC Trauma Unit	DHS commissions an outside quality group to review trauma services at KDMC. Found weaknesses in timeliness of patients going to the OR, monitoring of patients due to inadequate nursing skills, inadequate medical documentation, lack of ICU beds, inadequate quality improvement program, delays in radiology and patient diagnosis, lack of coordination between administration and medical professionals and between physicians and nurses, and delays in response of on-call back up surgeons.
11/24/04	**CMS Survey**	KDMC placed on Immediate Jeopardy with Patient Rights related to the use of weapons by Office of Public Safety officers.
12/27/04	DHS Senior Medical Director	DHS Senior Medical Director, Clinical Affairs and Affiliations hired.
1/31/05	JCAHO Status	Impact of loss of JCAHO accreditation assessed as a result of final appeals process.
2/1/05	JCAHO Notice	JCAHO provided decision of Appeal Review Committee determining that there is substantial evidence to support the accreditation committee's decision and concluded to deny accreditation effective 2/1/05. In California, loss of JCAHO accreditation requires loss of trauma center status.
2/4/05	CMS Response	CMS response submitted for 11/24/04 survey results.
2/7/05	Navigant Completes 60-day Assessment	Navigant proposes interim advisory board to assume roles and functions normally associated with a facility's governing board.
3/1/05	Trauma Services	Trauma services closed at KDMC.
3/11/05	Medical Administration	Medical Administration reconfigured to include an Associate Medical Director, Performance and Quality Improvement and an interim Director of Quality.
3/11/05	Laboratory survey	Laboratory passed its College of American Pathologists (CAP) survey.
4/1/05	Medical Staff	Peer review policies and procedures being developed; Hospital Quality Board pending formation of the KDMC Hospital Advisory Board (HAB).
4/22/05	Training	Physician training on supervision expectations, nursing training on sentinel event notification.
4/29/05	Recruitment	Met with search firm to delineate characteristics and job challenges for CEO, COO.
4/29/05	CMS & JCAHO Training	Physician managers completed regulatory training.

4/29/05	Code Carts	Ordered code carts to standardize equipment and supplies for responding to Code Blues.
5/5/05	Cardiac Monitors	New cardiac monitors ordered.
5/6/05	Evaluation of Affiliation Agreement with Drew	Assessment of the pace of reform submitted to BOS by DHS. Timeline set for Mock Survey to be conducted by outside agency; recruitment for executive positions of CEO, COO, Chief Nursing Officer; and proposed JCAHO re-accreditation survey date, initially for November 2005.
5/16/05	HAB	Hector Flores, MD named as chair of the HAB; subcommittees formed.
4/12/05-6/3/05	Director's Assessment	Dr. Garthwaite moved his office to KDMC for a period of several weeks. He met with department chairs and made rounds to assess problems and issues in each service. Ward rounds were made on an almost daily basis, including frequent concurrent review of charts. Issues raised by frontline staff on rounds were addressed. Outpatient clinic reform initiatives were also reviewed.
5/16/05	Peer Review	Expedited peer review process established for unexpected deaths.
5/27/05	Patient Safety Walk Rounds	Patient Safety Walk Rounds initiated to begin establishing a culture of safety by encouraging open and honest communication regarding patient safety, barriers to teamwork, "near misses" and error reporting.
5/27/05	HAB	First HAB Quality Subcommittee meeting.
5/27/05	Medical Records	Medical Records coders began reviewing charts on units.
5.27/05	Cardiac Monitors	New cardiac Monitors for telemetry unit ordered; allowing telemetry capabilities.
7/1/05	Nursing Clinical Leadership	Clinical Director of Medical Surgical Services hired.
7/1/05	Drew Provost	Thomas Yoshikawa hired as Provost of Drew University.
7/1/05	KDMC Options	Shattuck Hammond Partners, LLC engaged to explore contracting out options.
7/11/05	Pharmacy	New pharmacy director hired. Interdisciplinary medication management process begun.
7/28/05	Daily Calls	Daily conference calls with Senior Medical Director implemented to discuss sentinel events.

7/28/05	Future of KDMC	Review of Quality of Care and Patient Safety at KDMC. Identified key quality indicators that were not significantly different from national averages, identified improvements in ED triage time, number of patient falls, hospital length of stay, ventilator associated infections, and length of stay in the ED for patients who are admitted, overall ED triage times, ACLS protocol response rates, and discharging patients. Also identified positive trends in resident supervision, OR utilization, nursing assessment documentation, and nursing management of patient care. Overall data suggests improvements that have been made in some areas, but still need for generalized and institutionalized improvements across the organization.
7/31/05	Health Care Quality Team formed	First hospital-wide Healthcare Quality Team meeting held, which restructured the quality improvement, performance management process.
8/3/05	Drew's Progress in Meeting DHS Requirements	New Dean and GME Director are appointed, GME office restructured, development of a plan to identify ACGME deficiencies initiated, searches begun or completed for eight vacant chair positions, achieved compliance with reporting requirements, faculty converted to one year contracts, and stipends must be earned.
8/5/05	Future of KDMC	Data demonstrate signs of improvement in many areas, but a smaller clinical program will allow for concentration of management and resources on fewer inpatient clinical programs. DHS recommended scheduling Beilenson hearings to revise clinical footprint to close obstetrical services and inpatient pediatrics, including neonatal and pediatric intensive care units, and expand cancer screening, diabetic services and outpatient pediatric services.
9/22/05	Status of Affiliation Agreement	Identified improvement in compliance with the Medical School Operating Agreement (MSOA) requirements and continued positive progress.
9/26/05	Dual Track Contingency Plan-Status Report	Advised board of potential scenarios that may impact the $200M in funding based on CMS' assessment, including: Substantial compliance with all 23 conditions of participation, out of compliance and withdrawal of federal funding, out of compliance and partial withdrawal of federal funding. Identified contingency planning that includes contracting out options.
10/3/05	Beilenson Notices Posted	Set Beilenson hearing date for Tuesday, October 18, 2005, for proposed closure of obstetrics (OB) and inpatient pediatrics services.
10/7/05	Cancellation of Beilenson Proposed	Proposed cancellation of Beilenson due to State of California ruling that closure of OB would make KDMC ineligible for Disproportionate Share Hospital funding resulting in the loss of $29M or more.
10/7/05	Contingency Planning	Identified contingency planning for KDMC to include contracting out options, conversion to MACC options, and closure options.

10/8/05	HAB By-laws	Recommended creation of advisory councils for each DHS Network, and reconstitution of the HAB to focus on non-conflicted members who could create a new governance and operational model for an effective safety net system in LA County.
10/17/05	Code Carts	Carts ordered in April arrive and are implemented on nursing units.
10/17/05	Cardiac Monitors	Cardiac Monitors for telemetry units installed.

Where we are today?

Many improvements have been made. KDMC is a safer place today than at the time of its last JCAHO survey. The facility has been thoroughly reviewed by Navigant and the Department. The outline below demonstrates that most areas show signs of improvement and some are beginning to demonstrate sustained reforms. In many areas, improvements, while present, are not fully institutionalized yet. Continued training on policies and procedures, daily concurrent review of care with real-time corrections of identified problems and continued aggressive human resources actions to address identified problems are the critical elements to developing and maintaining a consistent level of care.

CMS and JCAHO surveys

As outlined in the introduction, the CMS survey and JCAHO surveys are different with respect to methodology and outcome. The differences between the two surveys are outlined in the following table:

CMS Certification	JCAHO Accreditation
Federal agency	Independent non-profit agency
Certification required for Medicare and Medicaid reimbursement	Voluntary, but many insurance/managed care contracts specifically require accreditation; can also certify for Medicare/Medicaid reimbursement with CMS' permission
Surveys 23 "Conditions of Participation"	Surveys 11 chapters of standards
Audit methodology (pull representative records and policies, validate adherence to the hospital's policies and CMS standards)	Tracer methodology (start with the record of a patient who is currently hospitalized, work back to the areas of the hospital and the processes that affect the quality of that patient's care)

CMS Certification	JCAHO Accreditation
Assesses compliance based on current conditions – focus is on actual bedside care on the day(s) of the survey	Requires 4-month track record of continuous compliance
Pass/Fail based on surveyor's assessment	o Accreditation o Provisional Accreditation o Conditional Accreditation o Preliminary Denial of Accreditation o Denial of Accreditation o Preliminary Accreditation

Readiness status for CMS survey

On October 10, 2005 the regional CMS representative indicated that the full Conditions of Participation in Medicare survey at KDMC would take place in the next 60 to 90 days. This survey assesses 23 Conditions of Participation. The table in below lists each of the 23 conditions, along with CMS findings at the time of its June 3, 2004 full validation survey and supplemented with findings from the October 2004 survey, and the current status of these conditions on a scale of 1 to 5, based on Navigant's assessment. The table also identifies the major risk areas as they currently exist, and the actions and interventions being undertaken to address these areas.

CMS Condition of Participation	Compliance Status as of October 2004	Navigant's Assessment of Current Compliance	Risk Areas	Actions and Interventions
Legend: 1 = non-compliance; 2 = minimal compliance; 3 = moderate compliance; 4 = significant compliance; 5 = substantial compliance				
Compliance with laws	3	3	▪ Title 22 requirements ▪ EMTALA violations	▪ New processes recently implemented
Governing body	1	4	▪ HAB maturity in role as governing body	▪ Time for HAB to mature

CMS Condition of Participation	Compliance Status as of October 2004	Navigant's Assessment of Current Compliance	Risk Areas	Actions and Interventions
Legend: 1 = non-compliance; 2 = minimal compliance; 3 = moderate compliance; 4 = significant compliance; 5 = substantial compliance				
Patients' rights	1	3	▪ Use of restraints	▪ Continue training ▪ Code 9 response has improved consistent with CMS standards
Quality assessment and performance improvement program	1	2-3	▪ Monitoring and analyzing data	▪ New QI structure in place; needs to mature
Medical staff	1	2-3	▪ Peer review ▪ Credentialing data ▪ Resident supervision	▪ Incorporating data into credentialing files
Nursing services	1	2-3	▪ Documentation of assessments and reassessments ▪ Care plans	▪ New forms recently implemented
Medical record services	1	2-3	▪ Legibility ▪ Documentation of History & Physicals ▪ Interdisciplinary care plans	▪ Daily chart review with feedback ▪ Delinquent chart reduction
Pharmaceutical services	1	2	▪ Documentation of Ordering ▪ Timeliness of administration ▪ Following up on effectiveness of meds	▪ Medical staff training ▪ On-line reporting of medication events {being calendared for Board approval)
Radiologic services	1	3	▪ 1200 radiology reports without final authentication	▪ Awaiting County Counsel decision on disposition
Laboratory services	5	5	▪ None	
Food and dietetic services	1	5	▪ Nursing screens for nutritional risk	▪ Nurse training ▪ New forms recently implemented

CMS Condition of Participation	Compliance Status as of October 2004	Navigant's Assessment of Current Compliance	Risk Areas	Actions and Interventions
Legend: 1 = non-compliance; 2 = minimal compliance; 3 = moderate compliance; 4 = significant compliance; 5 = substantial compliance				
Utilization review	4	5	▪ Some patient flow issues ▪ No major problems	▪ Continue work on patient flow issues
Physical environment	1	3	▪ Cleanliness	▪ Leadership in environmental services
Infection control	1	4	▪ Data analysis	▪ Maturation in data analysis processes
Discharge planning	3	5	▪ No issues anticipated	
Organ, tissue, and eye procurement	4	4	▪ No issues anticipated	
Surgical services (incl. Central Services)	1	3	▪ Post-operative reports ▪ Pre-op History & Physicals	▪ Daily chart checks ▪ Process redesign
Anesthesia services	3	3	▪ Pre-operative management	▪ Work with Anesthesia dept.
Nuclear medicine services	3	3	▪ Radiation management	▪ Monitoring ▪ Data feedback
Outpatient services	3	3	▪ Documentation of continuum of care	▪ Daily chart checks
Emergency services	1	2-3	▪ Patient throughput ▪ Clinical decision-making	▪ Full-time consultative medical management team from UCLA
Rehabilitation services	4	5	▪ Nursing functional assessments	▪ New forms recently implemented
Respiratory Care Services	1	3	▪ Medication control ▪ Securing medication rooms ▪ Contracted service	▪ Process redesign

Readiness status for JCAHO re-accreditation

Because the JCAHO accreditation survey emphasizes a track record of sustained performance for a period of several months, we will not schedule this survey until all necessary changes have been in place for a sufficient period of time to be viewed as "sustained". This means that we will likely request the JCAHO accreditation survey to be conducted during March 2006.

KDMC's readiness in each of the 11 standard areas of JCAHO compliance is outlined in the table below:

JCAHO Function/Chapter of Standards	Compliance Status as of Dec. 2004	Current Compliance Status	Risk Areas	Actions and Interventions
Legend: 1 = non-compliance; 2 = minimal compliance; 3 = moderate compliance; 4 = significant compliance; 5 = substantial compliance				
National Patient Safety Goals	1	2	▪ Six interdisciplinary patient safety goals require new procedures	▪ Implementing new procedures
Ethics, Rights and Responsibilities	2	3	▪ Informed consent ▪ Pain management	▪ Working with medical staff
Provision of Care, Treatment, and Services	1	2	▪ Nursing assessments ▪ Registry	▪ New forms implemented
Medication Management	1	2	▪ Medication security ▪ Documentation of prescribing ▪ Timeliness of administration ▪ Following up on effectiveness of meds	▪ Medical staff training ▪ On-line reporting of medication events {being calendared for Board approval) ▪ Nurse managers controlling med room access
Surveillance, Prevention and Control of Infection	1	4	▪ Hand hygiene	▪ Data analysis maturation

JCAHO Function/Chapter of Standards	Compliance Status as of Dec. 2004	Current Compliance Status	Risk Areas	Actions and Interventions
Legend: 1 = non-compliance; 2 = minimal compliance; 3 = moderate compliance; 4 = significant compliance; 5 = substantial compliance				
Improving Organization Performance	1	2-3	▪ Data analysis	▪ Data analysis maturation ▪ Quality Improvement program redesigned
Leadership	1	3	▪ Patient safety oversight	▪ Process maturing
Management of the Environment of Care	1	3	▪ Use of data	▪ Data process maturing
Management of Human Resources	1	2	▪ Performance evaluations ▪ Contract standards	▪ Continue recruitment efforts
Management of Information	3	3	▪ Legibility ▪ Documentation of History & Physicals ▪ Interdisciplinary care plans	▪ Daily chart review with feedback
Medical Staff	1	3-4	▪ Credentialing and peer review	▪ Incorporating data into credentialing files
Nursing	3	3	▪ Nursing leadership ▪ Policies & procedures	▪ Recruit Chief Nursing Officer

Plans for a successful transition

The Department has a straightforward plan for success given the challenges and uncertainties ahead for KDMC:

1) Continue to work closely with Navigant and KDMC to focus on sustained implementation of those policies and practices fundamental to passing the CMS audit.

2) Document ongoing monitoring and improvement so that it provides the necessary four-month time-in-place foundation for a JCAHO review.

3) Continue development and lead time implementation of a comprehensive contingency plan whose primary goal is to keep inpatients beds open at KDMC, but provides immediate and long-term alternatives should the facility be closed to inpatient services for a period of time.

The Department believes that KDMC continues to make progress toward meeting all CMS Conditions of Participation. The critical efforts toward a successful outcome given the time remaining include:

- Daily calls with Navigant staff to resolve all specific case and system issues on a real-time basis.
- Re-assignment of two senior DHS HSA staff to KDMC to monitor and assist in the implementation of Navigant of CMS recommendations.
- Bringing additional nursing management resources through a partnership with the Nursing Master's degree Program at the UCLA School of Nursing.
- Targeted intensive management of areas or functions with recurring problems. For example, UCLA's Department of Emergency Medicine has identified one full-time physician and one part-time physician from their staff who will be assigned to KDMC beginning October 17, 2005 for the next sixty days to help with implementation of critical bedside functions.
- Engagement of Drew University leadership to work with Navigant though weekly meetings to ensure that Department Chairs and physician staff are held accountable for physician management and medical staff functions.
- Implementation of a Navigant transition plan that continues their active participation in all the CMS preparations.

Barriers

Significant barriers to meeting CMS and JCAHO requirements remain that do not have simple solutions that can be implemented in the next sixty to ninety days - recruitment being the most important. As the Department and our consultants have worked to fix the long-standing problems at KDMC, between 1/26/04 and 10/6/05 we have found many employees that were unable to perform at the proper level. As of 10/15/05, there have been more than 700 personnel cases opened resulting in 458 corrective actions including 167 terminations or resignations. Nearly 30% of the workforce has required some human resources intervention. As a result, there continue to be gaps in leadership and management and we have had to spend considerable time and effort in recruitment. Due to the severe regional nursing shortage, both direct patient care and nursing management positions have been extremely difficult to recruit even with the ten percent premium pay at KDMC. Some of the nursing management positions have just recently been filled. DHS and Navigant are working diligently to integrate these new leaders into the new culture. Currently, over sixty percent of the KDMC's nurses are travelers and recruitment for the Chief Nursing Officer has been difficult.

The Department worked with the Hospital Association of Southern California (HASC) to convene a meeting of nursing leadership from private facilities with a goal of temporarily borrowing nursing managers. The meeting was very well attended, but ultimately the private facilities did not have any resources that they could spare; they are having serious recruitment problems themselves and most rely on registry staff. The other DHS facilities are in a similar position. There currently are many unfilled positions in nursing middle management across DHS and current staff is already spread thin trying to meet the needs within the other hospitals.

Recruitment of other personnel including physicians, and other health care professionals has also been difficult. Recruitment of service chiefs has been complicated by the uncertainty of KDMC's and Drew University's future.

The most successful recruiting tool for KDMC will be achieving positive results on the upcoming surveys.

Other significant barriers to meeting CMS and JCAHO requirements have included:

- the complexity and time delays of the County contracting process
- the time and effort necessary to pursue over 700 personnel cases
- the resistance to change among remaining staff
- the length of the contracts for traveling nurses was very short in the beginning due to their frustration with the old culture; with short contracts, more traveling nurses were new and required training
- the constant distraction of press inquiries, Board and Board staff inquiries, non-county politician interests, lawsuits, requests under the Freedom of Information Act, and meetings of all kinds
- the need to assess the competence of all staff and the difficulty in assessing whether those who initially did not meet competency standards could be trained to meet them

Key actions to address these barriers include the hiring of new executive leadership and several key middle management positions at the facility. While no one individual can turn a facility around, having a full-time permanent Chief Executive Officer provides a renewed basis for confidence among current staff and significantly helps with recruiting other management positions. The Department has also hired a full-time Director of Human Resources for the facility to expedite human resources actions at KDMC. A new "Safe and Just Culture" policy is being implemented system-wide.

The ideal outcome is that the CMS survey demonstrates that the facility meets the Conditions of Participation. With successful CMS compliance, KDMC will still have additional work to do to

sustain a four-month track record for all processes required under JCAHO standards. Key action steps include:

- This December, submit JCAHO survey application and request a March 2006 survey date
- Continue to work on implementation and monitoring of all the recommendations in the Navigant work plan related to JCAHO
- Continue targeted weekly internal JCAHO readiness audits
- Full external mock survey in late January 2006

The Department and CMS believe that there is a significant possibility that KDMC may have problems meeting all Conditions of Participation at the time of the survey. Conditions of Participation surveys commonly identify minor issues that facilities are expected to correct. Given the previous problems identified by CMS and the one-year MOU there is a significant chance that even minor instances of non-compliance would result in a finding of not meeting the Conditions of Participation. The Department does not expect that CMS will allow additional time for any additional corrective actions plans, even for minor or moderate issues and in the face of significant progress.

The Department has created and continues development of a comprehensive contingency plan should KDMC fail to meet CMS Conditions for Participation. A detailed description of the contingency plan was provided to your Board on October 7, 2005. If the facility loses accreditation there are two options available to meet the current inpatient needs provided by KDMC: there is a distributed model and a consolidated model. The distributed model requires contracting with private hospitals in the area surrounding KDMC for inpatient beds for the uninsured. The consolidated model requires a single entity to take over the operations of the hospital on the current KDMC site.

The Department strongly believes that the consolidated model is the preferred contingency option. This model would require contracting with a hospital or health care system with a demonstrated track record of running CMS and JCAHO approved hospitals. The Department continues its dialogue with Catholic Healthcare West (CHW) and expects a formal decision about their interest by the end of the year with a transition implemented as early as June 2006.

While the CHW discussions have been quite positive, there is always the possibility that these talks will not result in formal agreement or that CMS might summarily withdraw funding without any allowance for a transition period. The distributed model specifically addresses this situation. As described in the Department's contingency plan, if KDMC were to close, the Department recommends that the County subsidy currently allocated to KDMC be redistributed to meet the following goals:

- Conversion of KDMC into a Multi-Service Ambulatory Care Center (MACC), operated by DHS
- Increasing the number of staffed beds at other DHS hospitals
- Development of temporary Indigent Emergency Care Contracts with the private safety net hospitals that will likely absorb some of the 30,000 annual emergency visits currently at KDMC.
- Conversion of Augustus Hawkins Mental Health building to a free-standing psychiatric hospital with a psychiatric emergency room
- Implementing workforce reduction mitigation strategies

The Department believes that even if a CMS renders a negative determination, they are likely to continue some form of transition funding if there is a well-developed transition plan. The Department's contingency plan specifically addresses the need to shift to a distributed model more rapidly should the hospital lose its CMS funding or if the State were to withdraw the facility's license.

Please let me know if you have any questions or would like additional information.

TLG:BC:id